Young Adult Emergency Medical Authorization Form

Please attach to this completed form a copy of your child's health insurance card to facilitate prompt authorization of medical treatment in the case of an emergency.

Please Print Clearly

Participant's full name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

Doctor: _____ Phone: _____

Health Insurance: _____ Policy#: _____

Mother: _____ Phone: _____

Father: _____ Phone: _____

Alternate Relative or care provider: _____

Relationship: _____

Phone: _____

Known allergies: _____

Last tetanus shot: _____

Additional information/special instructions: _____

_____

_____ _____

Parent/Legal Guardian Signature Date

Form updated: 1/14